CalOptima
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Non-Emergency Medical Transportation (NEMT) Authorization Request

☐ **Routine: Fax to 714-338-3153** ☐ **Retrospective: Fax to 714-338-3153** ☐ **Urgent: Fax to 714-571-2424**

MEMBER INFO

Patient Name: _____ ☐ F ☐ M Date of Birth: _____ Age: _____

Medi-Cal Number (CIN): _____ Preferred language: Spoken: _____ Understands: _____

Patient Address: _____ City: _____ ZIP: _____ Phone: _____

☐ Home ☐ Board and Care ☐ ICF-DD ☐ SNF ☐ Other: _____

Facility Name: _____ Contact: _____

Facility Contact Direct Telephone Number: _____ Fax Number: _____

Primary Dx: _____ ICD-10: _____

PRESCRIPTION AND MEDICAL NECESSITY CRITERIA (Rx must be completed, signed and dated by attending physician)

Prescribing Physician: _____

NPI # _____

Phone: _____ FAX: _____

Address: _____

Primary Care Physician (PCP): _____

NPI # _____

Phone: _____ FAX: _____

Address: _____

NEMT required to receive medical services on: Date: _____ **Time:** _____

With: Name: _____ **Telephone Number:** _____

Approximate duration of NEMT need: _____ **Patient's current NEMT Provider:** _____

Ambulance, air ambulance, litter/gurney van and wheelchair van medical transportation services are covered when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for purposes of obtaining needed medical care. ***Diagnosis alone does not constitute medical necessity.***

Please mark member's qualifying medical necessity criteria: ** **Attach medical records to substantiate medical necessity****

☐ **Ambulance:** Member's medical condition contraindicates the use of other forms of medical transportation. (Member requires specialized equipment and/or personnel.) State functional limitations: _____

☐ **Litter/gurney van:** Member must be transported in a prone or supine position because member is incapable of sitting for the period of time needed to transport. State functional limitations: _____

☐ **Wheelchair van:** Member must be transported by wheelchair because of a disabling physical or mental limitation and is unable to self-transfer or self-propel. State functional limitations: _____

☐ **Air ambulance:** Member's medical condition or practical considerations render ground transportation not feasible. State functional limitations: _____

PHYSICIAN CERTIFICATION OF MEDICAL NECESSITY: California Code of Regulations [CCR], Title 22, Section 51323 was used as criteria to determine medical necessity for the type of transportation requested.

M. D. / D. O. / D. D. S. Signature: _____ **Date:** _____